Benefit Verification Form

Insurance Company:____

Deductible:____

Copay:____

Coinsurance:____

Visits Cap:____

Amount Used:____

Patient Name:____

(Print)

Signature:____________________________________ Date:______________

MayLath Therapy Group, Inc.

Financial Policy

Payment Policy

We bill all contracted insurance carriers, however if you fail to bring your insurance information with you to your first appointment, we may require payment at time of service. All co-pays are due at the time of service. We currently accept cash and checks. We do understand that patients may experience financial problems occasionally. If you need to arrange a payment plan, please contact our Business Office at 570-708-2525.

Regarding Insurance

We accept assignment of insurance benefits after your first visit. Our Financial Policy requires payment in full of any balance billed to you by our facility within 30 days of receiving a statement. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance may be automatically transferred to you. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for providing any/all information sent to you by your insurance company as no return of this information will result in payment being delayed or denied, thereby becoming your responsibility.

Regarding Insurance Plans where we are a participating provider. In the event that your insurance coverage changes to a plan where we are not participating providers you will need to inform our billing office immediately. In the event we are not a participating provider you may be responsible for part of or all of the expenses of your treatment. In the instance that our fees go towards meeting your yearly deductible, this deductible amount will be billed to you and payable within 30 days of receipt of statement. I hereby authorize my insurance company to make payment directly to Maylath Therapy Group, Inc. for any benefits I may receive. I authorize the release of any information necessary to process my insurance claims, or facilitate payment of my account by a third party. **Initials:_______**

Medicare Physical and Occupation Therapy Limits

To our Medicare Patients: The current Medicare cap is $1960.00 per calendar year for physical therapy and speech-language services combined. There is a separate yearly benefit limit of $1960.00 for outpatient occupational therapy. Medicare pays for Occupational, Physical, and Speech Therapy as long as it is medically necessary, but only up to the benefit limit of $1960.00. This is approximately 15 visits per calendar year. Medicare has an annual deductible of $166.00 and then pays at 80% with 20% being your responsibility, unless you have secondary insurance coverage. **Initials:________**

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **Initials:________**

Motor Vehicle Accidents

Maylath Therapy Group, Inc. is happy to evaluate and treat you for your motor vehicle related injury. We would like you to be aware that auto insurance companies cover physical, occupational and speech-language therapy benefits as long as there is Personal Injury Protection (PIP) available on the claim. We do call on every claim to verify if PIP is available; however, the adjustor may be unable to reveal the total dollar amount available. It is therefore, your responsibility as the patient to know and understand what benefits are covered. We will continue to bill your auto insurance until the PIP has expired and they deny any more payments. It is for this reason that we get a copy of your private medical insurance as a backup for billing services that may be denied. If you do not have private medical insurance the remaining balance will be your responsibility. **Initials:________**

Minor Patients

The adult accompanying a minor or the parents (or guardians of the minor) are responsible for full payment after insurance has paid their portion. For unaccompanied minors, physical therapy will be given only with the consent and signature of our Information and Financial Policy by the parent or custodial guardian. Co-pay arrangements will stand as referenced above. **Initials:________**

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read, understand and agree to the
Financial Policy.

Mayalth Therapy Group, Inc.
Patient Agreement to Treatment and Release of Information

ATTENDANCE AND CANCELLATION POLICY

I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment.

CONSENT FOR TREATMENT

I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and considered necessary or advisable by my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.

ACCESS TO AND RELEASE OF HEALTH INFORMATION

I understand that MAYLATH THERAPY GROUP, INC. may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and MAYLATH THERAPY GROUP, INC.'S administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received MAYLATH THERAPY GROUP, INC.'S Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY

I authorize the medical treatment, which has been or will be provided to me or my dependent, as named below, by MAYLATH THERAPY GROUP, INC., and that I am the responsible party for any such charges incurred. I represent that I presently maintain medical insurance coverage, which will reimburse the charges for the care provided. If my medical insurance coverage is not sufficient to satisfy these charges in full, I acknowledge that the resulting balance is not covered by this assignment and I will be fully responsible for payment of this balance at the established rates of MAYLATH THERAPY GROUP, INC.. I authorize the creditor to make a credit investigation, including employment verification, should this be necessary. I agree to be responsible for any reasonable collection costs and/or attorney's fees incurred in the collection of this account should it become delinquent. In consideration of medical services rendered by MAYLATH THERAPY GROUP, INC., I hereby assign, transfer, and set over to MAYLATH THERAPY GROUP, INC., all of my rights, title, and interest to medical reimbursement. I also authorize the release of any medical and/or billing information necessary to process claims. MAYLATH THERAPY GROUP, INC. will provide services without regard to race, color, national origin, ancestry, religious creed, sex, age or handicap.

This Agreement is entered into by and between Maylath Valley Health Systems, Inc., and

_____________________________________.

Print Patient Name

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily. I agree that the following information has been reviewed with me by a Maylath Therapy Group, Inc. staff member:

- **Attendance and Cancellation Policy**
- **Access to and Release of Health Information.**
- **Authorization of Treatment, Assignment of Benefits, and Financial Responsibility**
- **Patient Agreement to Treatment**
- **Patient Bill of Right**
- **Registration Information**
- **Patient Privacy Act/Privacy Act Statement**
- **Financial Responsibility Policy**

Please note that refusal to sign this form does not change responsibility for payment in any way.

_____________________________________ _______________

Patient Signature **Date**

_____________________________________ _______________

Staff Signature **Date**

As the representative of the above individual, I acknowledge receipt of the above information on his or her behalf.

_____________________________________ _______________

Signature **Date**

____

Relationship to Patient

Maylath Therapy Group, Inc.
Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current Outpatient Therapy Services Will End:

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current outpatient therapy services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Beneficiary and Family Centered Care Quality Improvement Organization (also known as a BFCC-QIO). A BFCC-QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The BFCC-QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the BFCC-QIO generally will notify you of its decision by the effective date of this notice.
- Call your BFCC-QIO **Livanta** toll-free at 1-866-815-5440 to request an appeal, or if you have quality of care concerns.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the BFCC-QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information ____

____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my BFCC-QIO.

____ __________________

Signature of Patient or Representative Date

Maylath Therapy Group, INC.
PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

As a patient of Maylath Therapy Group, Inc., you have the right to:

1) Be informed of your rights and responsibilities for receiving Outpatient services.

2) Choose your own health care provider. You have the right to know if there is a beneficial relationship between Maylath Therapy Group, Inc. and referring entities.

3) Be admitted to Maylath Therapy Group, Inc. only if the agency has the ability to provide safe, professional care at the level of intensity needed. When Maylath Therapy Group, Inc. can no longer meet your needs, you will be given information in a timely manner regarding anticipated transfer of your outpatient care to another facility, different level of care, termination of outpatient services to you and/or any other alternative you choose.

4) Be informed that you have the right to formulate an advance directive. If you have an advance directive, Maylath Therapy Group, Inc. will honor the advance directive as long as it does not violate State and Federal laws. The existence of an advance directive is communicated to all appropriate staff. These findings are respected by all staff to the extent provided by law. The non-existence of an advance directive will not hamper access to care and will not be discriminated against.

5) Be informed of and to participate in the planning of your care, treatment and goals. You have the right to be informed, in advance, about the care to be furnished and of changes in that care to be furnished.

6) Be informed of the disciplines that will furnish care and the frequency of visits proposed to be furnished.

7) Refuse care or treatment.

8) Be given appropriate and professional quality outpatient care without discrimination against your race, color, national origin, or on the basis of disability or age, ancestry, religious creed or sex. Complaints of discrimination may be filed with the Office of Equal Opportunity, Pennsylvania Department of Health, and/or The Pennsylvania Human Relations Commission.

9) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source by all who furnish outpatient services to you. Your property and belongings will be treated with respect. All patient clinical records are private and confidential. You have the right to access your record.

10) Be given complete information concerning your condition, diagnosis and treatment in a language you can reasonably be expected to understand.

11) Know that all patient clinical records are private and confidential and you have the right to access your records at any time.

1) Voice grievances regarding treatment or care that is (or fails to be) furnished or regarding the lack of respect for property by anyone who is furnishing services on behalf of the agency and must not be subjected to discrimination or reprisal for doing so.

2) Have the outpatient clinic investigate grievances/complaints made by the patient or patient's family or guardian. The outpatient clinic must document both the existence of the complaint and the resolution of the complaint and provide this information to the outpatient clinic administrator. If a violation is verified, corrective action must be taken and documented. All verified significant violations will be reported to the appropriate state and/or local bodies within five days of the incident.

3) Have your rights exercised as follows:

A. If you have been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf.

B. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.

4) Be given information if requested before care is initiated of the extent to which payment for outpatient services may be expected from Medicare or other sources and the extent to which payment may be required from the patient. Before care is initiated, the outpatient clinic must inform you orally and in writing, of:

A. The extent to which payment may be expected from Medicare, Medical Assistance, any other federally funded aided program, or private insurance company known to the outpatient clinic.
B. The charges for services that will not be covered by Medicare, Medical Assistance, any other federally funded aided program or private insurance and the charges that the patient may have to pay and be advised orally and in writing of any changes. The outpatient clinic must advise the patient of these changes orally and in writing as soon as possible but no later than 30 calendar days from the date the outpatient clinic becomes aware of the change.

1) Maylath Therapy Group, Inc. is a private, locally owned Outpatient Clinic.

As an outpatient patient you have the responsibility to:

1) Provide accurate and complete information concerning your past and present medical conditions including Advance Directives/Living Will.

1) Participate in the development or revision of your plan of care.

2) Provide information regarding any change in medical condition or treatment.

3) Provide information you may have regarding concerns or problems you have to a Maylath Therapy Group, Inc.'s staff member(s).

4) Be involved in conflict resolution, if required.

5) Request further information concerning anything you do not understand.

6) Treat all Maylath Therapy Group, Inc.'s staff members with courtesy and respect.

7) Inform Maylath Therapy Group, Inc. when you will not be able to keep an appointment.

8) For complaints, grievances or questions, please contact Christine Siegrist, Administrator of Maylath Therapy Group, Inc. at 570-708-2525.

9) For any response that you are not satisfied with or to lodge complaints regarding the implementation of advance directives requirements, call the The PA. Department of Health, Division of Home Health toll free hotline at 1-800-254-5164. The hotline is answered by a staff member, Monday thru Friday, from 7:30am-4:30 pm. After normal business hours, weekends and holidays, hotline callers will receive a recorded message stating the purpose of the hotline and the hours of operation.

Maylath Therapy Group, Inc.

HIPPA NOTICE OF PRIVACY PRACTICES
Mary Ann Miller, Privacy Officer, 570-708-2525
Effective Date:6/10/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

This clinic practice collects health information about you and stores it in a chart and on a computer in an electronic health record/personal health record. This is your medical record. The medical record is the property of this clinical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

A. How This Medical Practice May Use or Disclose Your Health Information

1. <u>Treatment</u>. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. <u>Payment</u>. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. <u>Health Care Operations</u>. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce

health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection

exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record may become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service,

your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

23. Disaster Relief. Maylath Therapy Group, Inc may disclose your protected information to disaster relief organizations to coordinate your care or notify family of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such disclosure whenever we practicably do so.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hard copy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. You will never be penalized for submitting a complaint.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Barbara Holland, Regional Manger
Office of Civil Rights
US Department of Health and Human Services
150 South Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, Pa, 19106-9111
Telephone #: 1-800-368-1019
Fax #:215-861-4431